Department of Health & Social Care

[redacted]
*Minister of State for Care*

*39 Victoria Street*
*London*
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[redacted]

Mr Hassan Shah
HM Assistant Coroner for Northamptonshire
The Guildhall,
St Giles' Square,
Northampton
NN1 1DE

[redacted]

1 April 2026

Dear Hassan,

Thank you for the Regulation 28 report of 19th February 2026, sent to the Department of Health and Social Care (DHSC), about the death of Mrs Jane Ann Fenwick**.** I am replying as the Minister with responsibility for adult social care.

Firstly, I would like to say how saddened I was to read of the circumstances of Mrs Fenwick's death; I offer my sincere condolences to her family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention.

The Prevention of Future Deaths (PFD) report raises concerns over:

1. The threshold for intervention and support for individuals such as Mrs Fenwick, who despite having a number of interconnected concerns about eating which could lead to choking, nevertheless was not referred to Speech and Language Therapy (SALT).
2. Current waiting lists for individuals such as Mrs Fenwick to be referred to SALT.

In preparing this response to your first concern, departmental officials have made enquiries with Care Quality Commission (CQC) and North Northamptonshire Council (NNC) and Chair of the Northamptonshire Safeguarding Adults Board (NSAB). Officials did this to gain a greater insight into any specific reasons for Mrs Fenwick not being referred to SALT and what, if any, follow up actions may have resulted from this case. However, with regards to the second concern, then NHS England, who also received a copy of this report, will be reporting separately on current waiting lists for SALT.

Any form of neglect is unacceptable, and my department recognises the importance of safe, person-centred care, particularly in relation to eating and drinking. This is why the Adult Social Care Learning and Development Support Scheme (LDSS), was launched in September 2024, and provides funding for eligible care staff to undertake courses and qualifications, including a Level 2 Certificate in Understanding Nutrition and Health and relevant content in the Level 2 Adult Social Care Certificate (L2ASCC).

The L2ASCC gives care workers the baseline competence to prevent and respond to choking. It includes nutrition and hydration training, how to identify and report related risks or changes, how to support individuals in line with their needs and care plans, and how to respond appropriately in emergencies, such as choking.

My officials have spoken to CQC, who have an open case concerning this incident, which was referred to the CQC's Specific Incident Progression Team in November 2025, for an initial fact-finding stage. The outcome of this fact-finding will determine whether CQC proceed with an investigation.

CQC note that risks associated with eating were not consistently addressed in practice and supervision did not occur on the day of the incident, although the care plan stated Mrs Fenwick should be observed while eating, as it identified a risk of choking.

Although no referral was made to SALT, local SALT advice to CQC indicated that although a full assessment might not have progressed, general guidance could have been provided had a referral been made. However, due to this case being ongoing, CQC cannot provide any further detail at this stage.

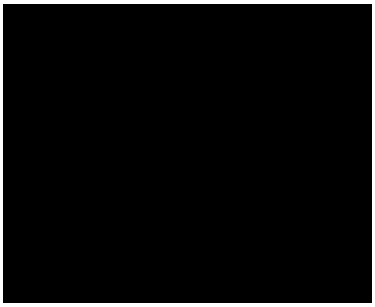
My officials also spoke to NNC and the NSAB Chair, and they confirmed with Northamptonshire Healthcare Foundation Trust (NHFT) Specialist Community Services that community referrals are triaged by SALT and the information provided is used to identify the referral as routine (within 13 weeks) or high priority (within 4 weeks). Once triage is completed the care homes are often given information and advised to trial alternative consistencies if appropriate, until they are able to visit. If a referral has been made with choking as a risk identified, it would however have been triaged as high priority.

Following inspection of documentation that my officials received from the NNC, including a timeline and care plan for Mrs Fenwick, as well as the additional information referenced above from NHFT, my officials have provided CQC with this additional information, to aid their fact-finding stage.

Separately NNC have indicated that in their view, although this was a tragic incident, it is being viewed as an isolated incident, as it has been determined that there are no similar risks to other people in the service or identified failings to warrant a Safeguarding Adults Review Referral under section 44 of the Care Act. However, the NNC will be engaging, alongside the NSAB, with the coroner and if any additional information becomes available, then NNC will consider this and any associated learning.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

Yours sincerely,



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